United Nations E/CN.6/2018/8

Economic and Social Council

Distr.: General
20 December 2017

Original: English

Commission on the Status of Women
Sixty-second session
12–23 March 2018
Item 3 (c) of the provisional agenda*
Follow-up to the Fourth World Conference on Women and to the twenty-third special session of the General Assembly, entitled "Women 2000: gender equality, development and peace for the twenty-first century": gender mainstreaming, situations and programmatic matters

Women, the girl child and HIV and AIDS

Report of the Secretary-General

Summary

In the present report, submitted pursuant to Commission on the Status of Women resolution 60/2 on women, the girl child and HIV and AIDS, the Secretary-General reviews progress made in the implementation of the resolution and describes measures taken by Member States and United Nations system entities. While extraordinary progress has been made in increasing the availability and use of antiretroviral therapy by women, challenges remain in ensuring treatment adherence and retention. Furthermore, new HIV infections are surging among adolescent girls and young women in high-prevalence settings. Ending the AIDS epidemic by 2030 will require a strengthened understanding of and an increased commitment to transformative responses to HIV and AIDS that are based on gender equality and the empowerment of all women and girls.

* E/CN.6/2018/1.

17-22997 (E) 120118

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I. Introduction

1. In 2016, at its sixtieth session, the Commission on the Status of Women adopted resolution 60/2 on women, the girl child and HIV and AIDS (see E/2016/27) and requested the Secretary-General to report on progress in implementing the resolution at its sixty-second session. The present report is based on contributions from 30 Member States[1] and eight United Nations entities.[2] It also includes information from recent research and evidence relevant to the issues outlined in the resolution.

II. Background

2. Over the past two years, countries have accelerated their efforts to end AIDS, making significant progress towards achieving Sustainable Development Goal target 3.3 of ending AIDS by 2030 and the fast-track targets for 2020 set out by the Joint United Nations Programme on HIV/AIDS (UNAIDS). The fast-track targets are that, by 2020: (a) 90 per cent of people living with HIV know their status, 90 per cent of people living with HIV who know their status are receiving treatment and 90 per cent of people receiving treatment have a suppressed viral load so their immune system remains strong and no longer transmits the virus; (b) fewer than 500,000 new HIV infections arise annually among adults; and (c) zero discrimination against people living with HIV and key populations is achieved.[3] In 2016, more than two thirds of people around the world living with HIV knew their HIV status, 77 per cent of people who knew their status were receiving antiretroviral therapy and 82 per cent of people receiving treatment had suppressed viral loads.[4] Also in 2016, the number of new infections declined to 1.8 million and countries made increased efforts to prevent discrimination against people living with HIV and key populations.[5]

3. In 2016, women aged 15 and older made up 52 per cent of the approximately 34.5 million [28.8 million–40.2 million] people living with HIV.[6] In 2016, it was estimated that there were approximately 790,000 [680,000–910,000] new HIV infections among women aged 15 and older, or 46 per cent of all new infections. There has been a notable increase in new HIV infections among adolescent girls and young women aged 15 to 24 in high-prevalence settings. According to UNAIDS estimates, in 2016, new infections among adolescent girls and young women aged 15 to 24 were

[1] Argentina, Australia, Brunei Darussalam, Cambodia, China, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Germany, Jamaica, Japan, Malta, Monaco, the Netherlands, Paraguay, Peru, Portugal, Romania, the Russian Federation, Spain, the Sudan, Swaziland, Togo, Trinidad and Tobago, Turkey, Turkmenistan, Uganda, and Zimbabwe.

[2] The Joint United Nations Programme on HIV/AIDS (UNAIDS), the Office of the United Nations High Commissioner for Refugees, the United Nations Development Programme (UNDP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime, the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) and the World Food Programme.

[3] Terminology guidelines from UNAIDS define key populations as people who inject drugs, sex workers, transgender people, prisoners and gay men and other men who have sex with men.

[4] UNAIDS, "Ending AIDS: progress towards the 90-90-90 targets — global AIDS update 2017" (Geneva, 2017).

[5] Ibid.

[6] Unless otherwise indicated, the findings in the present report are sourced from the estimates for 2017 in the AIDSinfo online database. Available from http://aidsinfo.unaids.org. Square brackets denote uncertainty bounds around estimates to indicate the range within which UNAIDS is confident that the point estimate lies.

44 per cent higher than they were among men in the same age group; in sub-Saharan Africa, the number of adolescent girls and young women aged 15 to 24 newly infected with HIV was double the number of young men. Despite the increased availability of antiretroviral medicines, AIDS-related illnesses remained the leading cause of death among women and girls of reproductive age (15–49) globally and the second leading cause of death among young women aged 15 to 24 in Africa.[7]

4. Women's ability to stay healthy is compromised by gendered social norms that place them at a disadvantage both in preventing HIV infection and in obtaining HIV services. Gender norms determine what is expected, allowed and valued in a woman in a given context. Expectations of how a woman should behave influence how much access women and girls have to information and services related to sexuality and reproductive health, including those related to HIV. Opportunities that women and girls have in terms of education, access to and control of resources and decision-making are socially determined and directly influence their ability to prevent HIV infection and mitigate its impact. Unequal gender norms translate into discriminatory laws and institutional biases that prevent women from being in full control of their lives and their health. Men often wield power over many aspects of women's lives and therefore play a key role in forming and enforcing gender norms. Addressing these norms, engaging with men and transforming gender biases in policies and institutions is essential for achieving a transformative HIV response.

III. Normative framework

5. In 2015, the General Assembly adopted the 2030 Agenda for Sustainable Development (resolution 70/1), including target 3.3 on ending AIDS by 2030, under Goal 3, to ensure healthy lives and promote well-being for all at all ages. Under the 2030 Agenda, Member States also adopted Goal 5, to achieve gender equality and empower all women and girls. Each of the targets under Goal 5 is critical to the HIV response and to ensuring that women and girls are free from AIDS. The Sustainable Development Goals and their HIV-related targets were reinforced by the Assembly at its high-level meeting on ending AIDS, held in 2016, at which Member States endorsed the Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030 (resolution 70/266, annex). In the Declaration, Member States highlighted the need to pursue transformative HIV responses that achieve gender equality and the empowerment of all women and girls. Member States agreed to implement gender-responsive national HIV strategic plans, promote women's leadership and engagement in the HIV response, address HIV intersections, violence against women and harmful practices and protect women's sexual and reproductive health and reproductive rights. Member States also committed to reducing the number of adolescent girls and young women aged 15 to 24 newly infected with HIV globally each year to below 100,000 by 2020.

6. In addition, at its seventy-first session, the General Assembly adopted resolutions that are relevant for addressing the gender equality dimensions of HIV and AIDS. In its resolution 71/175 on child, early and forced marriage, the Assembly recommended that Member States eliminate child, early and forced marriage and support girls and women who are at risk of or have been subjected to this practice.

[7] World Health Organization (WHO), "Health statistics and information systems: estimates for 2000–2015" (Geneva, 2017). Available from www.who.int/healthinfo/global_burden_disease/estimates/en.

Member States committed to increasing the availability of gender-responsive, adolescent-friendly information and health services on sexual and reproductive health, including HIV and AIDS. In resolution 71/170, concerning the intensification of efforts to prevent and eliminate all forms of violence against women and girls, the Assembly recognized the links between violence against women and HIV and urged Member States to promote efforts to ensure access to services for HIV.

7. The role of violence in increasing women's risk of HIV was reiterated by the Committee on the Elimination of Discrimination against Women in its general recommendation No. 35 (2017) on gender-based violence against women, updating general recommendation No. 19. In it, the Committee urged Member States to build the capacity of the judiciary, lawyers and law enforcement officers in sexual and reproductive health, including HIV, so they can act to prevent and address gender-based violence against women. In 2017, at its twenty-sixth session, the Commission on Crime Prevention and Criminal Justice adopted resolution 26/2, encouraging Member States to ensure access to measures for the prevention of mother-to-child transmission of HIV in prisons (see E/2017/30).

8. The commitment to women's rights, including their sexual and reproductive health and reproductive rights, was recognized in Human Rights Council resolutions 32/4 and 35/18 on the elimination of discrimination against women. In resolution 35/18, the Council urged Member States to promote, protect and fulfil the right of all women to have full control over, and to decide freely and responsibly on, matters related to their sexuality and sexual and reproductive health, free from discrimination, coercion and violence.

IV. Action taken by Member States and United Nations system entities

A. Advancing gender equality and women's empowerment through national HIV responses

Strengthening legal and policy frameworks for gender equality and women's empowerment

9. A transformative HIV response is not possible without a legal and policy environment that supports women's rights. Laws need to set out regulations to ensure that women, in particular adolescent girls, young women and women in key populations, have access to comprehensive sexuality and reproductive health information and services, including for HIV, and that their rights are protected. In a review of progress in addressing legal and policy barriers to universal access to HIV services in Asia and the Pacific, it was noted that women affected by HIV remain highly stigmatized, continue to face discrimination and high levels of violence that often goes unreported and have limited access to justice.[8] Many countries have removed requirements for parental consent that limit access to health services: of countries responding to the 2017 National Commitments and Policy Instrument, 29 per cent (32 of 110 responding) did not require parental consent for a child under 18 to access HIV testing, 44 per cent (48 of 109 responding) did not require parental

[8] UNDP, UNAIDS and the Economic and Social Commission for Asia and the Pacific, "Review of country progress in addressing legal and policy barriers to universal access to HIV services in Asia and the Pacific" (Bangkok, 2016).

consent for HIV treatment and 37 per cent (40 of 108 responding) did not require parental consent to access sexual and reproductive health services.

10. Child, early and forced marriage increases the vulnerability of adolescent girls and young women to HIV. They often have limited access to prevention information and less ability to negotiate condom use. Member States and United Nations system entities have implemented initiatives to end child, early and forced marriage. El Salvador, Trinidad and Tobago and Zimbabwe recently declared child, early and forced marriage illegal, and the Dominican Republic is updating its civil code to set the minimum age of marriage to 18. The United Nations Development Programme (UNDP) supported the Southern African Development Community Parliamentary Forum in developing a model law on eradicating child marriage. The United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) supported Malawi in adopting the Marriage, Divorce and Family Relations Law, which ended child, early and forced marriage, and, in 2017, the country introduced a constitutional amendment raising the minimum age of marriage to 18 years.

11. Female genital mutilation could increase girls' risk of HIV as a result of unsterilized surgical instruments.[9] Ending this harmful practice by enforcing legislation and strategies is essential to the prevention of HIV infection. Portugal and the Sudan reported implementing national strategies and programmes to eliminate female genital mutilation. The United Nations Population Fund (UNFPA) supported Eritrea, Mauritania, Nigeria and Uganda in allocating funds for interventions aimed at ending female genital mutilation.

Incorporating gender equality and women's empowerment in national HIV plans

12. Gender-responsive actions in the context of HIV are aimed at transforming unequal gender relations, promoting the equal sharing of resources and decision-making and ensuring a voice for women. Ensuring a comprehensive approach is a challenge. In a review of 18 national HIV strategic plans in sub-Saharan Africa,[10] it was found that gender equality targets in those plans were most commonly focused on the prevention of gender-based violence and on women's access to family planning. Strategies to integrate sexual and reproductive health and HIV programmes, improve rights or access to resources for women and girls and increase school access and attendance by adolescent girls and young women were identified in fewer than 6 of the 18 strategic plans.

13. Australia, Cambodia, Colombia, China, Costa Rica, the Dominican Republic, El Salvador, Portugal, the Russian Federation, Spain, Swaziland, Togo, Trinidad and Tobago, Turkmenistan, Uganda and Zimbabwe identified women and girls as a priority group in their national HIV plans and have programmes aimed at reducing their vulnerability to HIV infection. The national strategic plan (2016–2020) of Cambodia highlights the contribution of gender inequality and social marginalization to the vulnerability to HIV of most-at-risk populations. Some countries have national policies or plans specifically on gender and HIV. The national action plan on women, girls, gender equality, HIV and AIDS of Uganda is aimed at increasing gender

[9] WHO, "Health risks of female genital mutilation". Available from www.who.int/reproductivehealth/topics/fgm/health_consequences_fgm/en/.

[10] Jennifer Sherwood and others, "HIV/AIDS national strategic plans of sub-Saharan African countries: an analysis for gender equality and sex-disaggregated HIV targets", *Health Policy and Planning*, vol. 32, No. 10 (2017).

capacity at the planning, policy and programme implementation levels and coordinating research on the impact of gender-responsive interventions on HIV.

14. United Nations system entities provided technical support to Member States in their efforts to develop gender-responsive HIV plans. UN-Women supported Morocco in including the following aspects in its 2017–2021 national HIV strategy: violence and HIV intersections, HIV prevention, access to information and treatment for women and the promotion of the rights of women living with HIV. In Nigeria, UNDP provided support for integrating gender perspectives and human rights as a cross-cutting theme into the national HIV response.

Ensuring the engagement, leadership and participation of women and girls

15. Developing gender-responsive measures requires that policymakers and programme managers support the participation and leadership of women, who are best placed to identify and advocate for their needs and priorities. Over 80 per cent of Member States (61 of 76) reporting to the 2017 National Commitments and Policy Instrument said that women living with HIV participate in developing policies, guidelines and strategies for the elimination of mother-to-child transmission of HIV. Nevertheless, although networks of women living with HIV have, in many countries, taken the lead in addressing human rights violations, often at considerable risk to themselves, they often receive insufficient support and funding.[11]

16. Costa Rica builds the capacity of women's organizations in human rights, reproductive and sexual health and stigma and discrimination. It also works with organizations of women with HIV to advocate for sexual and reproductive rights and against violence. In Zimbabwe, networks of women living with HIV are represented in the national gender and HIV and AIDS technical working group and the country coordination mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria; they also monitor activities and conduct advocacy.

17. UNAIDS and UN-Women supported the #WhatWomenWant advocacy campaign organized by the ATHENA network to ensure that the voices of women and girls were heard during the global policy discussion at the 2016 high-level meeting on AIDS. UNDP strengthened the capacity of country coordinating mechanisms to support the leadership of women and girls living with HIV. UN-Women supported the International Community of Women Living with HIV in training women living with HIV on localizing the Sustainable Development Goals. In Ukraine, such training led to the country's first-ever forum on gender equality and HIV/AIDS and to a strategy, with key milestones, for women and girls living with HIV to engage in the national HIV response.

Financing for women and girls in the HIV response

18. In an assessment of public financing for the needs and rights of women in the context of the HIV epidemic in Latin America and the Caribbean, it was found that HIV funding earmarked for women was focused primarily on the elimination of mother-to-child transmission of HIV.[12] Information on funding allocated to other HIV-specific efforts, such as prevention, treatment and support for women, is limited.

[11] Rebecca Matheson and others, "Realizing the promise of the global plan: engaging communities and promoting the health and human rights of women living with HIV", *Journal of Acquired Immune Deficiency Syndromes*, vol. 75, supplement 1 (2017).

[12] UN-Women, "Rapid assessment: public funding for the needs and rights of women in the context of the HIV epidemic in Latin America and the Caribbean" (Panama City, 2017).

Explicit national investments for women and HIV continue to be focused on women in their roles as pregnant women and mothers. The growing urgency brought on by new HIV infections among adolescent girls and young women has resulted in increased funding, including catalytic funding from the Global Fund, which provides support for integrated HIV prevention, treatment and care programmes for adolescent girls and young women in 13 countries in Africa. It is critical for these financing approaches to recognize women's comprehensive needs related to HIV prevention and treatment and the realization of their human rights and thus expand on the current approaches that are focused on pregnant women and mothers.

19. Only 54 per cent of countries (37 of 68) reporting to the 2017 National Commitments and Policy Instrument and whose national HIV strategy or policy included interventions for transforming gender relations had a dedicated budget for implementing those interventions. As a result of advocacy work by UN-Women, the national AIDS coordinating authorities in Cambodia, Papua New Guinea and Rwanda increased their budgets for undertaking a gender analysis of their HIV responses and identifying funding for gender-responsive interventions. UNDP supported seven African countries in defining and costing interventions to address human rights and gender-related barriers in new funding requests to the Global Fund.

Measuring gender inequalities in HIV responses

20. The availability of HIV data, disaggregated by sex and age, is key for developing a gender-responsive approach to the HIV response. In a review of national HIV strategic plans in 18 countries,[13] however, it was found that only 31 per cent of targets include sex disaggregation. Data were particularly limited on antiretroviral therapy coverage and retention. Data were also limited on access to antiretroviral therapy for specific groups of women such as adolescent girls, young women, female sex workers and transgender women. Further gaps exist in relation to the documentation of women's experiences as patients, especially in relation to confidentiality, treatment literacy, disrespect and abuse. Strengthening the country-level monitoring and evaluation system requires clearly defined indicators that necessitate sex disaggregation where appropriate and a capacity for ongoing gender analysis.

21. Argentina was the only country reporting that provided data disaggregated by both sex and age to describe HIV diagnosis and treatment among young women. The continuous monitoring of data to determine performance gaps is facilitated by tools such as the dashboard of gender-responsive indicators developed by Uganda. The Netherlands completed its first inventory of the needs of women living with HIV. Results included findings that women were less positive about their physical health than men and that they experienced stigma more frequently than men.[14]

22. In 2017, the UNAIDS online Global AIDS Monitoring submission tool and the National Commitments and Policy Instrument were updated to increase the availability of data on gender, women's rights and gender equality. To help apply global guidance to country frameworks, UN-Women, UNDP and UNFPA helped to integrate gender-responsive indicators into monitoring frameworks in Kazakhstan, Tajikistan and Uganda. In Myanmar, UNDP and government partners conducted

[13] Sherwood and others, "HIV/AIDS national strategic plans".

[14] Rema Foppen, Luca Koppen and Fred Verdult, "Positive voices: tell me your story and I'll be your voice". Summary of research into quality of life (Dutch Association of People Living with HIV, 2015). Available from https://issuu.com/hivvereniging/docs/samenvattingpositiefgeluid-e-4web.

research on the socioeconomic impact of HIV, finding that female-headed HIV-affected households were almost 10 times more likely to go hungry.

B. Increasing access to quality HIV treatment, care and support for women and girls

Ensuring access and adherence to quality treatment

23. According to UNAIDS estimates, as at 30 June 2017, 20.9 million people had received antiretroviral therapy. Treatment coverage among women aged 15 and older had more than doubled since 2010 and was higher among women (60 per cent) than men of the same age group (47 per cent). Extraordinary progress has been made on women's access to HIV treatment. Between 2010 and 2016, the proportion of women aged 15 and over living with HIV who were receiving antiretroviral therapy increased from 24 per cent to 60 per cent. Progress is expected to accelerate further with the 2017 pricing agreement, which will increase the availability of the first affordable generic single-pill HIV treatment regimen.[15] World Trade Organization members can make full use of the flexibilities under the Agreement on Trade-Related Aspects of Intellectual Property Rights to improve research and development in affordable health technologies.[16]

24. Testing rates are generally higher for women than men,[17] thereby contributing to women's higher rates of treatment. HIV self-testing, assisted partner notification, mobile testing units and community-based HIV counselling and testing are potential new tools to increase testing, but their differential impact on women and men requires monitoring. In Zimbabwe, the proportion of female HIV self-testers who successfully sought treatment following a test was 50 per cent, compared with 80 per cent of males.[18]

25. The integration of HIV testing and treatment with sexual and reproductive health care services is becoming an important strategy in the response to HIV. Of the countries reporting under the National Commitments and Policy Instrument in 2017, 93 per cent had integrated HIV testing and counselling and 77 per cent had integrated HIV treatment and care with sexual and reproductive health services.[19]

26. According to UNAIDS estimates, more than 4 out of 5 people on treatment had suppressed viral loads in 2016, reflecting high rates of retention. However, specific

[15] UNAIDS, "New high-quality antiretroviral therapy to be launched in South Africa, Kenya and over 90 low- and middle-income countries at reduced price." Available from www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2017/september/20170921_TLD.

[16] United Nations Development Programme, "Report of the United Nations Secretary-General's High-level Panel on Access to Medicines: promoting innovation and access to health technologies" (2016).

[17] WHO, "WHO issues new guidance on HIV self-testing ahead of World AIDS Day", 29 November 2016. Available from www.who.int/mediacentre/news/releases/2016/world-aids-day/en.

[18] See Population Services International, "HIV self-testing Africa: STAR initiative". Available from http://psimpact.com/star-hiv-self-testing-africa.

[19] Percentages reflect reports by 109 of 117 countries responding on the integration of HIV counselling and testing with sexual and reproductive health services, 88 of 115 countries responding on HIV treatment with sexual and reproductive health services, 59 of 107 countries responding on HIV counselling and testing with cervical cancer services and 52 of 107 countries responding on cervical cancer screening with HIV services.

populations are more likely to drop out of treatment. Studies suggest that treatment retention is lower for young people and women in key populations, owing to stigma, discrimination and disclosure issues, as well as to travel and waiting times at clinics.[20] The current lack of sufficiently disaggregated data by age and sex, as well as data on treatment cascade outcomes for key populations, makes it difficult to understand which girls, women, men and boys have access to treatment and who is being left behind.

27. A study commissioned by UN-Women[21] revealed gender-related barriers in women's access and adherence to treatment across their life cycle, including violence and fear of violence, stigma and discrimination, low treatment literacy, care responsibilities and a lack of control over resources. United Nations system entities have developed tools to address discrimination in the health sector (see paras. 42–44 below) and to improve care for adolescents and young people[22] and key populations.[23] However, further work is needed to strengthen woman-centred HIV testing and treatment and to support treatment adherence. Access to treatment can also be strengthened for specific populations. The United Nations Office on Drugs and Crime established HIV prevention, treatment and care services in women's prisons in Pakistan, including referrals for antiretroviral therapy and managing the prevention of mother-to-child transmission of HIV.

Providing HIV care and support services to women and girls living with HIV

28. Comprehensive services for women and girls living with HIV include transportation, housing, childcare, mental health services, employment services, legal assistance and food vouchers. Typically, programmes are focused on eliminating mother-to-child transmission and often provide referral linkages. Women who do not seek maternal health services, however, may not have access to similar referrals.[24] Programme designers and managers need to engage women living with HIV in planning and monitoring activities to ensure that HIV care and support programmes not only meet women's needs but contribute to transforming gender norms.

29. Member States, including Argentina, Cambodia, China, Costa Rica, the Netherlands, Portugal, the Sudan, Togo, Trinidad and Tobago and Uganda, have made strong efforts to respond to the needs of women and girls living with HIV. Uganda established family support groups at health facilities to provide medical and psychosocial support to HIV-positive mothers. An evaluation found that members

[20] See, for example, Maya Petersen and others, "Association of implementation of a universal testing and treatment intervention with HIV diagnosis, receipt of antiretroviral therapy, and viral suppression in East Africa", *Journal of the American Medical Association*, vol. 317, No. 21 (2017).

[21] AIDS Vaccine Advocacy Coalition and others, *Key Barriers to Women's Access to HIV Treatment: A Global Review* (2017). Available from http://genderandaids.unwomen.org/-/media/files/un%20women/geha/resources/key%20barriers%20to%20womens%20access%20to%20hiv%20treatment%20-%20final.pdf?vs=1519.

[22] UNAIDS, "Ending the AIDS epidemic for adolescents, with adolescents: a practical guide to meaningfully engage adolescents in the AIDS response" (Geneva, 2016); and the United Nations Children's Fund (UNICEF), "Guidance document: strengthening the adolescent component of national HIV programmes through country assessments: adolescent assessment and decision-makers' tool (New York, 2015).

[23] UNDP, "Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions" (New York, 2016).

[24] Laura K. Beres and others, "Non-specialist psychosocial support interventions for women living with HIV: a systematic review", *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, vol. 29, No. 9 (2017).

were more likely to stay in care for at least 24 months, as compared with their counterparts who were not enrolled. In Trinidad and Tobago, the Positive Connections programme helps adolescents living with HIV, including girls, understand their diagnosis, participate in managing their care and treatment and identify strategies for positive living.

30. In the United Republic of Tanzania, UN-Women delivered business skills training to 3,000 rural women living with and affected by HIV, enabling them to launch their own small businesses, gain access to legal support and HIV services and have more control over decision-making in the household and the community. The Office of the United Nations High Commissioner for Refugees (UNHCR) established mother support groups in Ethiopia to encourage women to continue their antiretroviral therapy.

C. Providing universal access to HIV prevention

31. Between 2010 and 2016, new HIV infections declined by only 16 per cent, threatening the achievement of the fast-track targets of fewer than 500,000 new infections per year by 2020 and fewer than 100,000 new infections among adolescent girls and young women. Progress has been limited by challenges in implementing key prevention services, including the provision and use of condoms, voluntary medical male circumcision, harm reduction services and pre-exposure prophylaxis, and in ensuring they are complemented by interventions aimed at addressing gender inequality and violence against women. Behaviours and attitudes related to masculinity, in particular those that promote and perpetuate male dominance and control over women and violence against women, affect the ability of both men and women to prevent HIV infection. Progress is being made in developing microbicides, a promising female-controlled method for HIV prevention: research in 2016 found that the monthly vaginal ring reduced infections by approximately 30 per cent.[25] To accelerate prevention efforts, a global prevention coalition was jointly convened by UNAIDS and UNFPA in 2016 to champion the approaches outlined in the HIV prevention 2020 road map, which emphasizes the empowerment of adolescent girls, young women and key populations at risk, in particular through combination prevention.[26]

32. Member States most commonly described using behavioural interventions. In Uganda, seven faith-based organizations, organized under the Inter-Religious Council of Uganda, developed action plans on sexual and reproductive health, HIV and gender-based violence. Approximately 700 religious and cultural leaders were provided with orientation on sexual, reproductive, maternal, newborn, child and adolescent health, HIV and gender-based violence. Many Member States also scaled up condom programmes and introduced pre-exposure prophylaxis, expanding women's options for HIV prevention. Peer-led interventions can also empower community members and reduce stigma and discrimination. Brunei Darussalam,

[25] International Partnership for Microbicides, "Dapivirine ring: phase III results". Available from www.ipmglobal.org/our-work/our-products/dapivirine-ring/phase-iii-results.

[26] UNAIDS, "HIV prevention 2020 road map: accelerating HIV prevention to reduce new infections by 75%" (Geneva, 2017). Combination HIV prevention provides defined packages of services, including behavioural, biomedical and structural components, tailored to high-priority population groups within their specific local contexts. Structural approaches, such as social and cultural interventions and political, legal and economic strategies, are discussed in section E below on addressing root causes.

El Salvador, Jamaica, Malta, the Netherlands, the Sudan, Turkmenistan and Zimbabwe supported peer education programmes for priority populations.

33. In Cambodia, UNFPA helped to influence gender norms surrounding HIV, gender equality and healthy relationships through the Love9 television and radio show. A survey found that 92 per cent of viewers thought the show had helped them understand that condoms prevent sexually transmitted infections, including HIV.

Eliminating mother-to-child transmission of HIV and keeping mothers alive and well

34. According to UNAIDS estimates, the scale-up and improvement of services to prevent mother-to-child-transmission has reduced the annual rate of new HIV infections among children under 15 years of age by 54 per cent since 2000. The implementation of the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive: 2011–2015 contributed to an increase in HIV testing coverage among pregnant women and in the use of improved antiretroviral regimens, including Option B+.[27] To accelerate progress, the Start Free, Stay Free, AIDS Free framework was launched in 2016, at the high-level meeting on ending AIDS, by UNAIDS and the United States President's Emergency Plan for AIDS Relief. In 2016, Botswana, Namibia, South Africa, Swaziland and Uganda reached the Start Free, Stay Free, AIDS Free target of diagnosing and providing lifelong antiretroviral therapy to at least 95 per cent of pregnant and breastfeeding women living with HIV.[28] In 2016, Armenia, Belarus, Cuba and Thailand were certified by the World Health Organization (WHO) as having eliminated mother-to-child transmission. Challenges include supporting adherence to HIV treatment by young mothers and providing woman-centred care that recognizes and responds to women's comprehensive needs. In Japan, a manual for health-care workers was developed to support the elimination of mother-to-child transmission. It is important for HIV programmes to support women's priorities beyond their roles as mothers or expectant mothers and increase antiretroviral therapy coverage among all women.

35. UNFPA improved the quality of integrated maternal and HIV services by increasing antenatal testing for HIV and obstetric care for women living with HIV through midwifery programmes in 64 countries. The World Food Programme provided technical support for national programmes to eliminate mother-to-child transmission of HIV to ensure that pregnant women living with HIV also have access to food and nutrition support.

D. Addressing the high vulnerability of adolescent girls and young women

36. Adolescent girls and young women are influenced by their young age and by gender norms that put them at a disadvantage both in preventing HIV and in successfully accessing care. There are notable differences between the different age categories of adolescent girls and young women (10–14, 15–19 and 20–24), but analysis is hindered by limited data, in particular for the 10–14 age category. Access

[27] Option B+, recommended by WHO in 2015, involves providing the same triple antiretroviral drugs to all HIV-infected pregnant women beginning in the antenatal clinic setting, but also continuing this therapy for these women for life.

[28] UNAIDS, "Ending AIDS: progress towards the 90-90-90 targets".

to and uptake of treatment are often reported to be lower among adolescents aged 10 to 19 than among people in older groups.[29] Survey data on HIV knowledge showed that only 30 per cent of young women aged 15 to 24 from 35 countries in sub-Saharan Africa and 13.6 per cent of young women of the same age group from 23 countries outside of sub-Saharan Africa had correct and comprehensive knowledge about HIV.[30] Increased availability of data on the treatment cascade, disaggregated by both sex and age, would allow for a better assessment of the comparative risks faced by adolescent girls and young women. Of 114 countries reporting to the 2017 National Commitments and Policy Instrument, 70 (61 per cent) indicated that their national HIV plans included activities that explicitly addressed the needs of adolescent girls and young women.

37. Several Member States reported using behavioural and biomedical strategies to reach adolescent girls and young women (see paras. 39–41 below for an overview of structural interventions, including social protection programmes). Argentina and Malta used social media, while El Salvador, Jamaica, Malta, Turkmenistan and Zimbabwe described peer education programmes to provide adolescent girls and young women with information about HIV. The Sista2Sista mentorship programme in Zimbabwe, designed to empower girls to learn about their rights and advocate for themselves, provided peer support through clubs, reaching 9,882 vulnerable girls in 20 hotspot districts in 2016. Comprehensive sexuality education can support the adoption of safer sexual behaviours and contribute to reduced HIV transmission. As part of the Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern Africa, 15 countries provided comprehensive sexuality education in over 40 per cent of primary and secondary schools. These countries offered the standard minimum package of adolescent- and youth-friendly sexual and reproductive health services.[31] Brunei Darussalam, Cambodia, Romania and Turkey focused efforts in schools on HIV prevention, while El Salvador, Germany, Liberia, Malta, Monaco, Paraguay, Spain, Uganda and Zimbabwe addressed broader issues such as life skills and sexuality education.

38. Engaging adolescent girls and young women in leadership roles can assist them in their efforts to protect themselves from acquiring HIV. In Kenya, Malawi and Uganda, the "Engagement + Empowerment = Equality" programme supported by UN-Women mobilized more than 1,000 adolescent girls and young women to engage in the national, regional and global HIV response. The United Nations Educational, Scientific and Cultural Organization and the World Young Women's Christian Association, through a "Safe Space" model,[32] fostered dialogue between religious and community leaders and young women on issues such as HIV and AIDS, comprehensive sexuality education, child, early and forced marriage and gender-based violence.

[29] UNAIDS, "Ending the AIDS epidemic for adolescents, with adolescents".

[30] UNAIDS, "Start Free, Stay Free, AIDS Free: a super-fast-track framework for ending AIDS among children, adolescents and young women by 2020" (Geneva, 2016).

[31] The youth-friendly package of sexual and reproductive health services offered across the region includes general health check-ups, advice and counselling on puberty, sexual and reproductive health and sexuality, contraception, pregnancy testing and counselling, education, counselling, testing and treatment relating to HIV and other sexually transmitted infections, medical male circumcision, cervical cancer screening and immunizations. UNESCO, UNFPA and UNAIDS, "Fulfilling our promise to young people today: 2013–2015 progress review" (Paris, New York and Geneva, 2016).

[32] World Young Women's Christian Association, "Safe Spaces training guide", (Geneva, 2014).

E. Addressing underlying gender norms that increase the vulnerability of women and girls

Promoting the education of girls and the economic empowerment of women

39. Educating women and girls improves their health outcomes and reduces the risk that they will be infected by HIV.[33] Policies have encouraged families to keep their children in school through the provision of free schooling and through social protection measures such as cash transfers, child-focused grants, school feeding initiatives, teacher support and monitoring by parents. Studies have found that social protection programmes enable girls to stay in school, contribute to their safer sexual health and have a positive effect on HIV outcomes.[34]

40. Member States reported implementing multisectoral programmes to improve health outcomes and the socioeconomic empowerment of women and girls. These programmes included the DREAMS (determined, resilient, empowered, AIDS-free, mentored and safe women) Initiative[35] referred to in the responses from Swaziland, Uganda and Zimbabwe, which is aimed at reducing new HIV infections among adolescent girls and young women in 10 sub-Saharan countries. Interventions implemented by 55 partner organizations strengthen capacity for service delivery, keep girls in school, link men to services, support pre-exposure prophylaxis and support post-secondary school employment for young women. Between 2015 and September 2017, the rate of new diagnoses among adolescent girls and young women aged 15 to 24 declined by more than 25 per cent in 65 per cent of the highest HIV-burden districts implementing DREAMS Initiative interventions, while 14 districts experienced a decline of more than 40 per cent.[36]

41. In Malawi, South Africa and the United Republic of Tanzania, UNDP, the United Nations Children's Fund and the World Bank helped to cost cash transfer schemes targeting young women and adolescent girls, to prevent HIV. As a result of an economic empowerment programme supported by the International Labour Organization and UNAIDS in six countries in Africa, the proportion of women who reduced the number of their sex partners rose from 56 per cent in 2011 to 74 per cent in 2015, and the proportion of women who adopted HIV risk reduction strategies rose from 31 per cent in 2011 to 81 per cent in 2015.

Eliminating stigma and discrimination against women and girls living with HIV

42. The fast-track targets include zero discrimination, which is understood to be core to ending AIDS by 2030. Yet stigma associated with HIV continues to discourage many women and girls from being tested for HIV, seeking care if found positive or adhering to treatment. Women and girls also face stigma and discrimination in

[33] UNAIDS, "On the fast track to end AIDS: 2016–2021 Strategy" (Geneva: 2015).

[34] Benjamin Davis and others (eds), *From Evidence to Action: The Story of Cash Transfers and Impact Evaluation in Sub-Saharan Africa* (Oxford, Food and Agriculture Organization of the United Nations, UNICEF and Oxford University Press, 2016).

[35] The DREAMS Initiative is a $385 million public-private partnership to reduce HIV infections among adolescent girls and young women in 10 sub-Saharan African countries, with support from the United States President's Emergency Plan for AIDS Relief (PEPFAR), the Bill and Melinda Gates Foundation, Girl Effect, Johnson & Johnson, Gilead Sciences and ViiV Healthcare.

[36] PEPFAR, "Fact sheet: 2017 PEPFAR latest global results", November 2017. Available from www.pepfar.gov/documents/organization/276321.pdf.

education and workplace settings. A challenge for monitoring progress is measuring stigma on a regular basis.

43. Swaziland has a separate national strategy for combating stigma and discrimination, and other countries have included strategies to reduce stigma in their national HIV plans. Argentina established a toll-free hotline for enquiries and reports of stigma and discrimination against people living with HIV. Costa Rica and Ecuador train health providers on stigma and discrimination. To measure progress, Australia is developing a specific indicator for stigma and discrimination, to be included in routine surveillance and monitoring. Organizations in Zimbabwe used the findings from the People Living with HIV Stigma Index to advocate for improved rights for people living with HIV.[37] Ongoing monitoring will help to identify interventions that most effectively reduce stigma and provide data on progress towards achieving zero discrimination.

44. Twelve United Nations system entities signed a joint statement on ending discrimination in health-care settings to encourage health care that is responsive to the needs of women living with HIV. UNDP supported 10 African countries in strengthening human rights programmes for HIV by removing legal barriers and supporting advocacy, strategic litigation and capacity-building for legal professionals.

Ending the twin epidemics of gender-based violence and HIV

45. Gender-based violence is a fundamental violation of women's human rights. It takes multiple forms, including rape and sexual violence, harmful practices and forced sterilization. Gender-based violence and fear of violence exacerbate the risk for women of acquiring HIV. Women experiencing or fearing intimate partner violence are 50 per cent more likely to acquire HIV[38] and have poor outcomes when receiving antiretroviral therapy.[39] In 2016, 83 per cent of Member States (89 of 117) reporting to the 2017 National Commitments and Policy Instrument had legislation against domestic violence in place, while 50 per cent (52 of 105) had integrated violence screening and mitigation in HIV services in all or some health facilities. Violence is especially prevalent in the lives of women in the sex industry[40] and women and girls in conflict areas. While estimates vary, data suggest that some 32 to 55 per cent of sex workers experience work-related physical and/or sexual violence in a given year.[41] A global study on the implementation of Security Council resolution 1325 (2000) found that women and girls in conflict areas had less access to HIV information, fewer resources for HIV prevention and significant barriers to negotiating safer sex.[42]

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[37] UNAIDS and others, "The People Living with HIV Stigma Index". Available from www.stigmaindex.org.

[38] Lori Heise and Elizabeth McGrory, "Greentree II: violence against women and girls, and HIV — report on a high-level consultation on the evidence and implications" (London, STRIVE Research Consortium, 2016).

[39] Sarah T. Roberts and others, "Intimate partner violence and adherence to HIV pre-exposure prophylaxis (PrEP) in African women in HIV serodiscordant relationships: a prospective cohort study", *Journal of Acquired Immune Deficiency Syndromes*, vol. 73, No. 3 (2016).

[40] Information from paragraphs 45–47 is drawn from UNAIDS work on the lives of sex workers.

[41] Kathleen N. Deering and others, "A systematic review of the correlates of violence against sex workers", *American Journal of Public Health*, vol. 104, No. 5 (2014).

[42] UN-Women, *Preventing conflict, transforming justice, securing the peace: a global study on the implementation of United Nations Security Council resolution 1325* (New York, 2015).

46. Eliminating all forms of violence against women and girls requires concerted action at all levels, from national guidelines to community mobilization.[43] Cambodia described the development of new referral and health sector guidelines for women and girls experiencing violence and a toolkit on gender-responsive HIV programming for use by the Commune Committees for Women and Children. In El Salvador, each municipality developed its own plan for preventing violence against women.

47. UN-Women, UNDP, WHO and UNFPA supported the design and implementation of national action plans on gender-based violence in Argentina, Paraguay, Peru and Viet Nam. In Viet Nam, this led to the adoption of an operational framework to implement the country's 2016–2020 national action plan on gender equality, which includes measures to prevent sexual violence and provide integrated services for gender-based violence and HIV. In its national plan against gender-based violence for 2016–2021, Peru recognized violence against women living with HIV. UNFPA and UNDP supported countries in integrating interventions for gender-based violence into the concept notes that serve as grant applications for the Global Fund, while UNHCR advocated for those concept notes to include gender equality issues faced by women affected by humanitarian emergencies and conflict.

Engaging men and boys in the promotion of gender equality in the context of HIV and AIDS

48. A gender-responsive and transformative approach to the HIV response is not possible without the involvement and support of men and boys. Social expectations about how men should behave may encourage men to take risks that may harm their health or prevent them from seeking timely HIV testing, counselling, treatment and care services, putting both themselves and their female partners at risk. Reducing the number of new HIV infections through a gender-responsive approach requires that men understand the risks of HIV, that they protect themselves and their partners and that they value balanced, responsible and respectful relationships. Men who support gender equality are less likely to condone risk-taking and aggressive sexual behaviour against women and girls and are valuable allies in implementing a transformative HIV response.

49. Member States took steps to increase men's support for gender equality and the rejection of gender norms that encourage risky behaviour. In Uganda, the kabaka (king and traditional leader) of the Kingdom of Buganda is serving as the male engagement ambassador for ending AIDS, with the aim of engaging 1 million men to be tested for HIV, access services and receive treatment. Men participating in the "One man can" campaign in South Africa reported an increased capability to overcome masculinity-related barriers to obtaining HIV services. They also reported an increased ability to express vulnerability and discuss HIV openly with others and a greater willingness to be tested for HIV and receive services. About a quarter of men participating in a campaign evaluation said they had been tested for HIV as a result of their involvement.[44]

50. In 2016, UNAIDS launched a platform for action on the rights, roles and responsibilities of men and boys to fast-track the end of AIDS. National consultations

[43] Sustainable Development Goal target 5.2 is to eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.

[44] Paul J. Fleming and others, "What role can gender-transformative programming for men play in increasing men's HIV testing and engagement in HIV care and treatment in South Africa?", *Culture, Health and Sexuality*, vol. 18, No. 11 (2016).

on creating an enabling policy environment that ensures men's access to services and reduces gender-based violence are under way in Eastern and Southern Africa. The "HeForShe" campaign, a global initiative by UN-Women, has engaged millions of men around the world in striving for a more gender-equal world.

V. Conclusions and recommendations

51. During the reporting period, significant progress was made in reducing the number of new HIV infections and in ensuring that more people know their HIV status, are put on treatment and achieve viral suppression. For women, however, the results have been mixed. Rates of new infections are high among adolescent girls and young women in sub-Saharan Africa and have increased among women in key populations in Eastern Europe and Central Asia. Women, in particular young women, continue to be disadvantaged in preventing HIV and obtaining HIV services as a result of discriminatory social norms about how women should think and behave, not only in terms of their sexual and reproductive health and rights, but in society in general.

52. Consequently, the Commission may wish to encourage Member States:

(a) To commit to implementing an HIV response that is gender-responsive and transformative, as agreed upon in the 2016 Political Declaration on HIV and AIDS and in support of Sustainable Development Goals 3, to ensure healthy lives and promote well-being for all at all ages, and 5, to achieve gender equality and empower all women and girls. Such strategies need to include efforts beyond preventing gender-based violence and promoting women's access to family planning to include: (i) supporting women beyond their roles as mothers or expectant mothers in the realization of their human rights; (ii) supporting and reinforcing women's sexual and reproductive health and rights; and (iii) addressing harmful gender norms through social dialogue between women and men, leadership on gender equality at the policy, legal and institutional levels, communication on social and behavioural change and increased visibility and advocacy of women's organizations;

(b) To support and engage women, including those representing key populations, in planning and implementing the transformative HIV response. Such efforts also contribute to the achievement of target 5.5 of the Sustainable Development Goals on ensuring women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life;

(c) To expand the use of gender-responsive budgeting to ensure that resources are allocated more efficiently where they are most needed. In particular, funding should target HIV prevention among adolescent girls and young women, improvements to the quality of HIV care centred on women's rights and needs, and capacity-building and programme implementation by women's organizations;

(d) To expand the collection, reporting and use of data disaggregated by sex and age, data on discrimination and data on identified harmful gender norms in order to target the HIV response more efficiently;

(e) To implement specific strategies to ensure that women and girls who may not necessarily be reached through existing HIV testing and treatment

services, including adolescent girls, young women, women in key populations, older women or women who are not seeking antenatal care, have access to HIV testing and treatment;

(f) To strengthen the quality of women-centred care so as to ensure that women's comprehensive rights and needs related to HIV prevention, treatment and care services are met by developing and implementing health sector guidelines and protocols for such non-medical needs as experienced violence and fear of violence, stigma and discrimination, low treatment literacy, lack of control over resources and mobility, and care responsibilities;

(g) To accelerate combination prevention, in particular among adolescent girls and young women, including through increased availability of female-controlled methods to prevent sexual transmission of HIV and by addressing the underlying risk factors that cause high HIV infection rates among adolescent girls and young women, in particular gender inequality, sexual violence and a lack of education;

(h) To continue the reform of legal and policy frameworks in support of gender equality and women's empowerment, including through Sustainable Development Goal targets 5.3, on eliminating all harmful practices, such as child, early and forced marriage and female genital mutilation, and 5.a, on undertaking reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property, financial services, inheritance and natural resources;

(i) To continue to work towards ending discrimination and violence against women and girls, including those living with HIV and key populations, in support of Sustainable Development Goal targets 5.1 and 5.2 on ending all forms of discrimination and eliminating all forms of violence against all women and girls, and to measure results by strengthening data monitoring and reporting systems. Until discrimination against women and girls living with HIV is significantly reduced in the health sector, in communities, in schools and in families, it will continue to hinder women from preventing HIV, obtaining comprehensive, woman-centred treatment and adhering to treatment.

53. The Commission may wish to encourage United Nations system entities and other international actors:

(a) To draw on priorities that have been identified by women themselves, when developing guidelines, tools and technical support strategies, in order to ensure that women's needs are met throughout their life cycle;

(b) To assist countries in pursuing a comprehensive approach to the realization of gender equality and the empowerment of all women and girls, including an understanding of the health impacts of gender norms on women's rights and an understanding that gender equality and women's empowerment requires going beyond the mere availability of services for women (such as family planning and antenatal care) to addressing the root causes of the unequal status of women and the power dynamics between women and men;

(c) To support and engage women, including adolescent girls, young women and women from key populations, in developing strategies to improve HIV prevention, testing, antiretroviral therapy and care and support for women, all of which requires a comprehensive articulation of the goal of gender equality

and women's empowerment, including the participation of women at all levels of decision-making;

(d) To increase the collection and reporting of data disaggregated by sex and age and data on discrimination and to develop strategies to routinely monitor HIV-related stigma and discrimination in order to effectively report on progress towards achieving the target of the 2016 Political Declaration on HIV and AIDS to eliminate HIV-related stigma and discrimination;

(e) To strengthen guidance on women-centred delivery of HIV treatment services to increase treatment adherence, by focusing on improving the quality of care, in particular through understanding women's gender- and age-specific needs and through the respectful treatment of women;

(f) To expand advocacy for combination HIV prevention among adolescent girls and young women in high-prevalence countries and women in key populations in low-prevalence countries, accelerate the development and distribution of female-controlled methods of preventing sexual transmission of HIV and support the scale-up of interventions that improve not only women's and girls' HIV outcomes but that help realize women's and girls' enjoyment of their human rights and of non-discriminatory social norms, which are necessary to ensuring long-term success in ending AIDS.